

North Dakota Veterans Home-Skilled Care
1400 Rose St. /PO Box 673
Lisbon, ND 58054-0673
Telephone number: (701) 683-6530 Fax number (701) 683-6550

Thank you for your interest in the ND veterans Home. Your application will be given immediate attention. You can help the application process by submitting the following documents or information with your application.

Application- fully completed

Medical

Medical certificate form 10-10SH, current information from the current nursing home or hospital

Level of screening for nursing home care

Documents (copies of)

DD214 (Report of Separation, Military Record of Service)

Widow(er) needs to submit veteran's death certificate

If applicable: Guardianship papers, conservatorship paper, Power of Attorney, Durable Power of Attorney

Copy of current Drivers License

Insurance Information

Copies of insurance cards, including Medicare and secondary insurance if applicable, copy of Medicaid card

Copy of current vehicle insurance

Financial Information

Verification of income and assets, copy of bank statement, IRAs etc.

After the application is received, it is reviewed for completeness, eligibility and level of care. The applicant or interested party will receive a call from the Admission's Office to schedule an admission date and time, indicate placement on waiting list, or advise you if we are unable to meet the needs required. A letter will follow the phone call.

Thank you for your cooperation. If you have any questions or wish to know the status of your application, please call (701) 683-6530

**APPLICATION FOR ADMISSION
NORTH DAKOTA VETERANS HOME
SKILLED CARE UNIT
PO Box 673, Lisbon, ND 58054
Phone: (701) 683-6530, Admissions Coordinator**

Personal Information:

Name: _____ Phone: _____
(Last, First, Middle Initial)

_____ City _____ County _____ State _____
Permanent Address

Where have you lived in the past 2 years? (City, County, State)

Social Security Number

_____ Date of Birth _____ Age _____ Place of Birth _____ Religion _____

_____ Father's Name _____ Living or Deceased?

_____ Mother's Name _____ Living or Deceased?

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

_____ Name of Spouse _____ Address _____ Phone Number _____

Is there a Power of Attorney established? ☐ Yes ☐ No

Name & Address of Power of Attorney _____

Is there a designated Legal Guardian? ☐ Yes ☐ No

Name & Address of Guardian _____

Do you own your own vehicle? ☐ Yes ☐ No _____

_____ Do you have auto insurance? ☐ Yes ☐ No _____ Year _____ Make _____
Company Name Policy Number

Do you have a driver's license? ☐ Yes ☐ No _____

Driver's License # Exp. Date Vehicle
License #

Do you have a police or criminal record? ☐ Yes ☐ No

If yes, briefly describe if it was a felony:

Have you ever been a member of the Veterans Home? ☐ Yes ☐ No

Reason for
leaving: _____

Previous Occupation

Last date of employment

Who would you like notified in case of an emergency?

Name Address/Phone Relationship

Financial Information:

Do you handle your own funds? ☐ Yes ☐ No

If no, please explain: _____

Income Source:

Gross
Monthly:

Monthly Debts:

VA

\$

Medicare

\$

VA Pension

\$

Private Insurance

\$

VA Compensation

\$

Medications

\$

Social Security

\$

Other

\$

Social Security Disability

\$

Retirement

\$

Do you pay co-pay for medications at the VA? ☐ Yes ☐ No Amount: \$ _____

Type of assets:

Amount:

Checking Account

\$

(Name & Address of Bank)

Savings Account

\$

(Name & Address of Bank)

Automobile	\$
Real Estate	\$
(Describe)	
Other Property	\$
(Describe)	

Who will pay your bills? ☐ Self ☐ Other _____ -

Name & Address

Insurance Information:

Are you eligible for Medicare? ☐ Yes ☐ No _____
 Medicare Number

Part A effective date _____ Part B effective date _____

Are you covered by Medicaid? ☐ Yes ☐ No Medicaid #: _____

Do you have other health insurance? ☐ Yes ☐ No

Name & Address of _____
 insurance company

Insurance Numbers _____

Military Information:

Service in the Armed Forces: ☐ Self ☐ Spouse Dates of Service: _____ to _____

_____ Type of discharge _____ Branch of Service _____ Rank _____

Serial Number _____ Claim Number _____ Service organization with Power of Attorney

Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No	Service in Persian Gulf Theatre	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prisoner of War	<input type="checkbox"/> Yes	Dental injury	<input type="checkbox"/> Yes

Where?	<input type="checkbox"/> No		<input type="checkbox"/> No
Combat Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Service Connected _____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No
Military Disability (retired from military for disability)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving Aid and Attendance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vietnam Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving Housebound	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lebanon Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving VA Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Panama Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving VA Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persian Gulf Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Service in Somalia	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you currently receiving VA Compensation for a service connected disability? ☐ Yes ☐ No

If yes, what is your VA compensation for?

What is your condition?_____

Are you receiving Aid and Attendance from the Veterans Administration? ☐ Yes ☐ No

Do you have a VA outpatient card? ☐ Yes ☐ No

Do you use the Fargo VA system for medical care? ☐ Yes ☐ No

I understand that under the Title VII of Civil Rights Act of 1964, I cannot be discriminated against based on race, color, religion, national origin, sex, or on the basis of age, physical, or mental handicap.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Signed this _____ day of _____, 20_____,
_____.

Signature of Applicant

Application explained and witnessed by

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CERTIFICATION OF RESIDENCY

This is to certify that _____ has been a resident of North
Dakota for 30 days and a resident of _____ County prior to
date of this application and is personally known as the individual whose name
appears on this application.

Print Name

Signature of Witness

Title